

Kansas Medical Assistance Program Prior Authorization Request Form for Non-Preferred Drugs

If you would like to prescribe a Preferred Drug,
Please do so in the space provided and
FAX form back to the dispensing pharmacy.

Otherwise, continue with the Prior Authorization
process by completing the rest of this form &
FAX completed form to the Prior Authorization Unit
@ 1-800-913-2229 (274-5956 Topeka)

Rx

Physician signature

Date

DRUGS for Hyperlipidemia - Fibric Acid Derivatives

Preferred

This includes all generic equivalents

Drug Covered

Fenofibrate

Tricor®

Triglide®

Non-preferred

Prior Authorization Required

Fenofibrate

Antara®

Lofibra®

PA is not required

Gemfibrozil

PA is not required

Lopid®

**** Indicates REQUIRED information**

****CONSUMER NAME:** _____

****Medicaid Number:** _____

****PHARMACY NAME:** _____

****Medicaid Number:** _____

****Phone Number:** _____

****Fax Number:** _____

****NDC:** _____

****PRESCRIBING PHYSICIAN NAME:** _____

****Medicaid Number:** _____

****Phone Number:** _____

****Fax Number:** _____

**** Indicate:** Non-Preferred Drug prescribed: _____ Other: _____

**** Check:** the appropriate box indicating medical necessity for the Non-Preferred Drug
and provide the requested information:

☐

Medical intolerance to Preferred Drug. **Provide clinical symptoms:** _____

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Inadequate response to Preferred Drug.

**** Indicate:** Preferred Drug tried: _____ Length of trial: _____

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Absence of appropriate formulation or indication of the drug. Please specify: _____

****Prescribing Physician's signature:** _____ **Date:** _____

If the pharmacy provider has started a Prior Authorization request and this information is not received within 15 working days, the PA request will be denied. **For questions related to Prior Authorization, contact 800-285-4978, option #3 or 274-5499, in Topeka.** General support is provided at 800-933-6593. For questions related to pharmacy issues, contact the Pharmacy Help Desk toll-free at 866-405-5200.